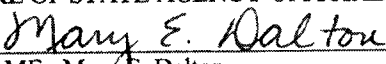



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 13-030	2. STATE Montana
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 07/01/2013	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 1902(a)(30)(A)		7. FEDERAL BUDGET IMPACT: a. FFY 13 \$555,151 b. FFY 14 \$2,240,205 c. FFY 15 \$1,724,258	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 4.19B Methods & Standards for Establishing Payment Rates, Service 19D. Targeted Case Management Services for Youth with Serious Emotional Disturbance (SED), Page 1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): 4.19B Methods & Standards for Establishing Payment Rates, Service 19D. Targeted Case Management Services for Youth with Serious Emotional Disturbance (SED), Pages 1-3	
10. SUBJECT OF AMENDMENT: The Targeted Case Management for SED amendment increases the rate by the amount appropriated by the 2013 Legislative Session and updates the date of the fee schedule on the Attachment 4.19B Introduction Page.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Montana Dept of Public Health and Human Services Mary E. Dalton, State Medicaid Director Attn: Jo Thompson PO Box 4210 Helena MT 59604	
13. TYPED NAME: Mary E. Dalton			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: 9/16/13			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 6/27/13 - revised 9/16/13		18. DATE APPROVED: 9/23/13	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/13		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: RICHARD C. ALLEN		22. TITLE: ARA, DNCHO	
23. REMARKS:			